Virginia PRE-ADMISSION *Screening*
Mental Illness Level II Instrument

SECTION I: IDENTIFICATION

1. Name: _____ _____ _____
Last First MI

2. Gender: ☐ M ☐ F 3. DOB: _____ 4. Age: _____

5. Private Pay: ☐ No ☐ Yes 6. Medicaid#: _____ 7. SSN: _____

8. CSB Name: _____ 9. Evaluation Date: _____
(Catchment Area)

10. Evaluation Location: ☐ NF ☐ Hospital ☐ Home ☐ Other (specify)_____

11. LPASC: _____ Contact Person: _____
(Title)

Address: _____ City: _____ State: _____ Zip: _____

Telephone: ( ) _____

12. Per documentation in chart, does the individual have a **LEGAL GUARDIAN?** ☐ No ☐ Yes
If "Yes", complete the following:

Name: _____ Phone#: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship: ☐ Parent ☐ Child ☐ Sibling ☐ Spouse ☐ Friend ☐ Other *(specify)*: _____

13. DSM-IV Current Diagnoses: Axis I: Primary _____ Secondary _____

Axis II: Primary _____ Secondary _____

Axis III: Related Condition _____

SECTION II: PSYCHOSOCIAL

1. Marital status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Unknown

2. Education:

☐ Less than high school ☐ Some high school ☐ High school graduate
☐ Some college ☐ College graduate ☐ Special Education
☐ Unknown

3. Last full-time employment position held: _____

4. Reasons for admission (*check all that apply)*:

☐ Cannot manage household ☐ Fear for personal safety ☐ Isolation
☐ Convalescent care ☐ Financial problems ☐ No primary caregiver
☐ Decline in ADLs ☐ Illness/disease
☐ Emergency placement ☐ Other (*specify)*: _____

5. Is this person able to evacuate a building in 3 minutes unassisted? ☐ No ☐ Yes

Name: _____

SECTION II: PSYCHOSOCIAL (Continued)

6. Provide history to substantiate MI diagnosis:

_____

_____

_____

_____

_____

_____

_____

_____

_____

7. Are there current and ongoing family supports? ☐ No ☐ Yes
Please describe:

_____

_____

_____

SECTION III: LEVEL OF FUNCTIONING

1. Basic Functional Status: *Coding 1=Independent 2=Verbal Assistance 3=Physical Assistance 4=Dependent*

( ) Transferring	( ) Bladder	( ) Bowel	( ) Prepares for bed
( ) Toileting	( ) Self medication	( ) Eating	( ) Dressing/undressing
( ) Bathing	( ) Personal hygiene	( ) Brushing teeth	( ) Selecting appropriate clothes

2. Advanced Functional Skills: *Coding 1=Independent 2=Verbal Assistance 3=Physical Assistance 4=Dependent*

( ) Housework	( ) Use of telephone	( ) Use of money	( ) Goes outdoors safely
( ) Care of clothing	( ) Use of transportation	( ) Manage finances	( ) Treat minor ailments
( ) Meal preparation	( ) Shopping	( ) Use of leisure time	( ) Monitor health status
( ) Employment	( ) Understands time	( ) Respond to emergencies	( ) Attend medical appts.

3. Cognitive skills: *Coding 1=Independent 2=Verbal Assistance 3=Physical Assistance 4=Dependent*

( ) Prepares for daily activities	( ) Understands 1 step instructions	( ) Stays on task
( ) Arranges for transport	( ) Understands multi-step instructions	( ) Completes assignments
( ) Expresses needs and wants	( ) Learns new skills	( ) Transfers skills

4. Sleep Pattern *(mark one)*:

☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep ☐ Severely disturbed pattern

5. Ambulation: (check as needed to describe resident's ability to ambulate)

☐ Fully independent	☐ Unsteady	☐ Aids (cane/walker/assis.by 1)	☐ Wheelchair/indep.
☐ Wheelchair/assisted	☐ Chairfast or Posey support	☐ Bedfast	☐ Other (specify):_____

Name: _____

SECTION III: LEVEL OF FUNCTIONING (Continued)

6. Assistive Devices: Describe the extent to which corrective/adaptive/prosthetic/mechanical devices could improve the individual's functional capabilities:

_____

_____

_____

_____

_____

SECTION IV: MEDICAL HISTORY

1. **Psychotropic Medication**

Record any psychotropic medications that have been prescribed and note any changes in dosage in the last three months.

Drug Code/Name	Purpose	Dosage	Freq	Change	Response to Rx

2. **STAT/PRN Administration of Medication**

In the last 60 days, has the individual received an emergency (STAT) or PRN administration of medication to control her/his behavior?

☐ No ☐ Yes

If "yes," please indicate the medication that was administered and the behavior for which the medication was administered:

3. **Physician Review**

Is a physical examination completed and signed by a licensed physician in the last 12 months attached?

☐ Yes, skip Physical Assessment.
☐ No, the Physical Examination Supplement must be completed and signed by a licensed physician.

4. **Comments:**

5. _____ (_____) _____ _____

QMHP Signature Telephone Number Date

Name: _____

SECTION V: PSYCHIATRIC ASSESSMENT

1. **Affective Behavior Observations**

a. Physical Features *(mark all that apply):*

☐ Clean/Tidy ☐ Poor hygiene/Unwashed ☐ Well-groomed
☐ Careless/Dishevelled/Sloppy ☐ Normal street dress ☐ Wearing bedclothes
☐ Makeup or jewelry ☐ No apparent effort at personal appearance
☐ Non-seasonal clothing ☐ Other *(specify):* _____

b. Level of Consciousness *(mark all that apply):*

☐ Alert ☐ Drowsy ☐ Attentive ☐ Inattentive ☐ Lethargic ☐ Other *(specify):* _____

c. Manner *(mark all that apply):*

☐ Warm ☐ Shy ☐ Threatening ☐ Concerned about others ☐ Outgoing nature ☐ Silly ☐ Sincere ☐ Apathetic ☐ Aggressive ☐ Sense of humor ☐ Suspicious
☐ Easily frustrated ☐ Childlike ☐ Reluctant to Respond ☐ Other *(specify)*: _____

d. Mood and Affect *(mark all that apply):*

☐ Appropriate in quality and intensity to stated themes
☐ Flat or blunted

☐ Depressed	☐ Mild	☐ Moderate	☐ Severe
☐ Anxious, fearful or worried	☐ Mild	☐ Moderate	☐ Severe
☐ Angry, belligerent or hostile	☐ Mild	☐ Moderate	☐ Severe
☐ Delusional	☐ Mild	☐ Moderate	☐ Severe
☐ Suicidal	☐ Mild	☐ Moderate	☐ Severe
☐ Homicidal	☐ Mild	☐ Moderate	☐ Severe

☐ Other *(specify):*_____

e. Form of Thought *(check all that apply):*

☐ Coherent	☐ Incoherent/Illogical	☐ Blocking	☐ Tangentiality
☐ Relevant	☐ Irrelevant/Rambling	☐ Impoverished	☐ Circumstantiality
☐ Logical	☐ Loose Associations	☐ Perseveration	☐ Pressured

f. Orientation Level *(mark one):*

☐ Oriented X3; clear at all times	☐ Oriented X3; forgetful at times	☐ Oriented to person and place
☐ Oriented to person	☐ Oriented to situation	☐ Oriented to bathroom/bed
☐ Confused at times in day	☐ Confused at times at night	☐ Disoriented X3
☐ Nonresponsive	☐ Unable to determine	

g. Communication Ability *(check all that apply):*

☐ No problems	☐ Reads	☐ Writes	☐ Speech unclear/slurred	☐ Gestures/aids
☐ Inappropriate content	☐ Stammer/stutter/impediment		☐ Eye contact	☐ Unresponsive

h. Socialization *(mark all that apply):*

☐ Appropriately responds to others' initiations
☐ Appropriately initiates contact with others
☐ Inappropriate responses/interactions *(describe)*: _____
☐ Withdrawn

i. Attitude *(mark one):*

☐ Cooperative ☐ Oppositional ☐ Agitated ☐ Guarded

Name: _____

SECTION V: PSYCHIATRIC ASSESSMENT (Continued)

2. **Chart of Behavior** *Complete the chart, based on all available information for the last 3 months, including information from the individual's medical records and staff comments:*

	Frequency		Frequency
☐ Dangerous smoking behavior		☐ Destroys property	
☐ Refuses medications		☐ Exposes self	
☐ Uncooperative diet		☐ Is sexually aggressive	
☐ Uncooperative hygiene		☐ Abuses--verbally	
☐ Refuses activities		☐ Threatens--verbally	
☐ Refuses to eat		☐ Threatens--physically	
☐ Self-induces vomiting		☐ Strikes others--provoked	
☐ Impatient/demanding		☐ Strikes others--unprovoked	
☐ Frequent/continuous yelling		☐ Talk of suicide	
☐ Wanders		☐ Suicidal threats	
☐ Tries to escape		☐ Suicidal attempts	
☐ Seclusiveness		☐ Injures self	
☐ Suspicious of others		☐ Other *(specify)*:	
☐ Lies purposefully		☐ Other *(specify):*	
☐ Steals deliberately		☐ None	

3. **Placement in Seclusion/Physical Restraints/Behavior Change(s)**

In the last 60 days, has the individual been placed in seclusion or other physical restraints to control dangerous behavior?

☐ No ☐ Yes

If "yes," describe the behavior and type of restraints:

4. **Comments:**

SECTION VI: DETERMINATION RECOMMENDATION

1. Name: _____ _____ _____
Last First MI

2. SSN: _____ 3. Medicaid #: _____

4. The individual has, or may have, one or both of the following diagnoses:

Mental Retardation? ☐ No ☐ Yes If yes, specify Level _____
Related Condition? ☐ No ☐ Yes If yes, specify Condition _____

5. As substantiated by your evaluation, does the individual meet the DSM-IV criteria for dementia or a related disorder in the absence of a **primary major mental illness**?

☐ No, continue
☐ Yes, substantiate below

Rationale: _____

_____

_____

6. As a result of a major mental disorder, the individual has functional limitations in the following areas (mark all that apply):

a. Interpersonal functioning

☐ 1. Difficulty interacting appropriately/communicating effectively with other persons
☐ 2. A history of altercations, evictions, firing, fear of strangers
☐ 3. Avoids interpersonal relationships
☐ 4. Is socially isolated
☐ 5. Other (specify): _____
☐ 6. None

b. Concentration, persistence and pace

☐ 1. Difficulty in sustaining focused attention to complete work tasks
☐ 2. Difficulty in sustaining focused attention to complete home tasks
☐ 3. Inability to complete tasks within established time period
☐ 4. Makes frequent errors or requires assistance in the completion of tasks
☐ 5. Other (specify): _____
☐ 6. None

c. Adaptation to change

☐ 1. Difficulty in adapting to typical changes associated with work, school or family
☐ 2. Manifests agitation, exacerbated signs and symptoms associated with the illness
☐ 3. Withdraws from the situation
☐ 4. Requires intervention by MH or judicial systems
☐ 5. Other (specify): _____
☐ 6. None

7. As a result of a major mental disorder, the individual has required treatment within the last two years for:

☐ Psychiatric treatment more intensive than outpatient care
☐ Episodes of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officers
☐ None

Name: _____

SECTION VI: DETERMINATION RECOMMENDATION (Continued)

8. Does the individual meet the DSM-IV criteria for a serious mental illness?

☐ No

☐ Yes, check at least one of the following and substantiate below (P=primary S=secondary)

P	S		P	S	
☐	☐	1. Anxiety disorder	☐	☐	8. Panic disorder
☐	☐	2. Atypical psychosis	☐	☐	9. Paranoid disorder
☐	☐	3. Bi-polar disorder	☐	☐	10. Schizoaffective disorder
☐	☐	4. Delusional disorder	☐	☐	11. Schizophrenia
☐	☐	5. Depression	☐	☐	12. Somotoform disorder
☐	☐	6. Major affective disorder	☐	☐	13. Other *(specify):*_____
☐	☐	7. Mood disorder	☐	☐	14. Other *(specify):*_____

Rationale: _____

9. **SPECIALIZED SERVICES RECOMMENDATION**

Does the individual require specialized services for SMI (**Inpatient psychiatric hospitalization**) ?

☐ No

☐ Yes, Substantiate below

Rationale: _____

10. **MENTAL HEALTH SERVICES RECOMMENDATION**

Does the individual require mental health services of a lesser intensity? ☐ No ☐ Yes (Mark all that apply)

CURRENT MENTAL HEALTH SERVICES	RECOMMENDATIONS Continue	Discontinue	New
☐ 1. Psychiatric consultation	1. ☐	☐	☐
☐ 2. Behavior management	2. ☐	☐	☐
☐ 3. Day treatment/partial hospitalization	3. ☐	☐	☐
☐ 4. Crisis intervention	4. ☐	☐	☐
☐ 5. Outpatient psychiatric	5. ☐	☐	☐
☐ 6. Psychotropic medication management	6. ☐	☐	☐
☐ 7. Psychosocial rehabilitation	7. ☐	☐	☐
☐ 8. Targeted case management	8. ☐	☐	☐
☐ 9. Other, specify_____	9. ☐	☐	☐

Justification/comments: _____

11. Print Assessor's Name: _____ Title: _____ Telephone:(_____)_____

Name: _____

SECTION VII: DMHMRSAS OFFICE USE ONLY MI/MR AUTHORITY FINAL DETERMINATION

NF Placement Appropriate? ☐ Yes ☐ No

Specialized Services Determination for SMI ☐ Yes ☐ No

Mental Health Services ☐ Yes ☐ No

- ☐ 1. Psychiatric Consultation
- ☐ 2. Behavior Management
- ☐ 3. Day Treatment/Partial Hospitalization
- ☐ 4. Crisis Intervention
- ☐ 5. Outpatient Psychiatric
- ☐ 6. Psychotropic Medication Management
- ☐ 7. Psychosocial Rehabilitation
- ☐ 8. Targeted Case Management
- ☐ 9. Other, specify

Nursing Facility Activities _____ ☐ Yes ☐ No

In OBRA process ☐ Yes ☐ No

Diagnosis(es) ☐ SMI ☐ RC ☐ DUAL
☐ MR ☐ MR/RC **F** MI/MR
F MI/RC

DMHMRSAS Determination Rationale:

Comments:

DMHMRSAS Authority: _____
OBRA Consultant Date

Telephone: (804) 371-2134 FAX: (804) 786-1836